DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Brandywine Nursing & Rehabilitation **DATE SURVEY COMPLETED: May 6, 2021**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual, and complaint survey was conducted at this facility from April 29, 2021, through May 6, 2021. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was one hundred fifteen (115). The survey sample totaled sixty six (66) residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**	**Cross reference CMS 2567 – L**	June 21, 2021
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed May 6, 2021: F677, F690, F803, F810 and F880.	1. The facility Staffing Coordinator was educated by the NHA on the requirement of maintaining the minimum 3.28 ppd direct nursing care ratio. 2. Staffing will be reviewed daily by the DON or the NHA to ensure staffing ratio meets the 3.28 minimum. 3. The Staffing Coordinator will be educated as to maintaining minimum staffing ratio each day and implementation of the facility emergency staffing policy which includes utilization of off duty staff and healthcare staffing	
16 Del. C., 1162	**Nursing Staffing:** **(c) By January 1, 2002, the minimum staffing**		

Provider's Signature _____ Title NHA Date 5/31/21

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	level for nursing services direct caregivers shall not be less than the staffing level re-quired to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement. **Nursing staff must be distributed in order to meet the following minimum weekly shift ratios:** **RN/LPN** **CNA*** **Day** **1 nurse per 15 res.** **1 aide per 8 res.** **Evening** **1:23** **1:10** **Night** **1:40** **1:20** *** or RN, LPN, or NAIT serving as a CNA.** **(g) The time period for review and determining compliance with the staffing ratios under this chapter shall be one (1) week.** A desk review staffing audit was conducted by the State of Delaware, Division of Health Care Quality, Office of Long Term Care Residents Protection on May 6, 2021. The facility was found to be out of compliance with 16 Delaware Code Chapter 11 Nursing Facilities and Similar Facilities. Based on review of facility documentation it was determined that for one day out of 21 days, the facility failed to provide staffing at a level of at least 3.28 hours of direct care per resident per day (PPD). Findings include: Review of facility staffing worksheets, completed and signed by the Nursing Home Administrator, revealed the following: 3/23/2020 PPD = 2.1	agencies. 4. The Director of Nursing or designee will conduct weekly audits x 4 weeks and monthly audits x 3 to ensure steps are taken to achieve minimum staffing ratio. Results of the audits will be submitted to the QAPI Meeting.	

Provider's Signature _____ Title NHA Date 6/21/2021

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	5/6/2021 at 2:45 PM – E1 (NHA) confirmed the failure to meet staffing requirements. E1 stated they had 12 call outs that day which resulted in the low number of PPD hours. The facility failed to maintain the minimum PPD staffing requirement of 3.28.		

Provider's Signature _____ Title NHA Date 6/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085004	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGS REHABILITATION AT BRANDYWINE	505 GREENBANK ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility beginning 4/29/21 through 5/6/21. The facility census the first day of the survey was 115. During this period, an Emergency Preparedness survey was also conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. For the Emergency Preparedness survey, no deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual, complaint, and emergency preparedness survey was conducted at this facility from 4/29/21 through 5/6/21. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was one hundred fifteen (115). The survey sample size was 66. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; FSD - Food Service Director; LPN - Licensed Practical Nurse; MD - Medical Doctor; NHA - Nursing Home Administrator; OT - Occupational Therapist; RN - Registered Nurse; ST - Speech Therapist;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/28/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 BPH (Benign Prostatic Hypertrophy) - enlarged prostate gland; Dementia - a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation OR loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; Foley catheter - tube held in the bladder by a small balloon to drain urine; MAR - medication administration record; Mechanical soft diet- smoother texture than regular foods; eliminates foods that are difficult to chew or swallow; mL (milliliters) - metric unit of liquid volume, 5 ml equals 1 teaspoon; Regular Diet - Normal diet with no texture limitations or modifications; food is left in it's whole form and liquids are served in its original form; TAR-treatment administration record where nurses write when an ordered treatment is completed; Tracheostomy - an opening made in the throat to assist breathing; UTI - urinary tract infection.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, facility documentation and interview it was determined that for one (R46) out	F 677	1. R46 was provided oral hygiene based on resident' individual needs. E9 was	6/21/21

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F 677	Continued From page 2 of five residents reviewed for ADL's the facility failed to provide oral care. Findings include: Review of R46's clinical record revealed: 12/12/19 - The resident profile documented that R46 required total dependence for hygiene and grooming. 1/31/21 - A care plan was initiated for ADL self-care performance deficit documented that R46 was totally dependent on staff with assist of one for personal hygiene and oral care. 3/2/21 - The annual MDS documented that R46 was totally dependent to maintain personal hygiene, including brushing teeth. 4/29/21 10:12 AM - Crust was observed around the corners of R46's mouth and there was gunk build up at the base of the gums. 5/3/21 9:25 AM - Crust was observed around the corners of R46's mouth and his bottom teeth were visible with gunk build up at the base of the gum. 5/3/21 1:35 PM - Crust was observed around the corners of R46's mouth and his bottom teeth were visible with gunk build up at the base of the gum. 5/3/21 1:35 PM - During an interview, R46 revealed that oral care was not provided. 5/5/21 approximately 12:15 PM - During an interview with E9 (CNA), E9 stated that the CNA's are not responsible for oral care on patients with tracheostomies.	F 677	educated on the importance of oral care to all residents. 2. Residents with tracheostomy will be reviewed to assure that oral care is provided based on resident's plan of care. 3. Nursing staff will be educated by Director of Nursing or designee on the importance of providing oral care to tracheostomy residents. 4. The Director of Nursing or designee will complete weekly audits x 4 and monthly x 3 until compliance is achieved to assure oral care is provided. Results of the audits will be submitted to the QAPI Committee.	

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F 677	Continued From page 3 5/5/21 12:35 PM - During an interview with E8 (UM), it was revealed that the CNAS's are responsible for oral care. During an exit interview with E2 (DON) and E11 (RNAC) on 5/5/21 around 2:10 PM, the deficient practice was confirmed. 5/6/21 3:00 PM - Findings were reviewed with E1 (NHA) and E2 during the exit conference.	F 677		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690		6/21/21

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F 690	Continued From page 4 prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, interview and review of facility documentation as indicated, it was determined that for one (R414) out of two sampled residents for catheter care, the facility failed to ensure that a resident with an indwelling catheter received appropriate treatment and services as per the plan of care to prevent urinary tract infections. In addition, a facility nurse implemented a standing order for "may irrigate urinary catheter as needed" without following the facility procedure, including to notify the physician. Findings include: 11/5/15 (last reviewed) - Centers for Disease Control and Prevention (CDC) Guidelines for Prevention of Catheter-Associated UTI (urinary tract infection) stated, "Unless obstruction is anticipated (e.g., as might occur with bleeding after prostatic or bladder surgery) bladder irrigation is not recommended." Review of R414's clinical record revealed: 11/18/20 - R414 was admitted to the facility from an acute care hospital. 11/18/20 - A care plan was initiated that R414 had	F 690	1. R414 was discharged from the facility.E15. E16 and E17 were educated by the Director of Nursing on identifying signs and symptoms of a UTI in residents with a catheter and notify the physician of any changes. 2. All residents with indwelling catheters were assessed to assure that they received appropriate treatment and services per plan of care to prevent urinary tract infections. 3. Professional nursing staff (RNs, LPNs) will be educated by the DON or designee on ensuring that residents with indwelling catheters receive appropriate treatment and services as per the plan of care to prevent urinary tract infections. 4. DON or designee will complete weekly audits x 4, monthly x 3, until compliance is achieved, to ensure the residents with indwelling catheter received appropriate care and services to prevent urinary tract infections. Results of the audits will be submitted to the QAPI Committee.	

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F 690	Continued From page 5 a foley (tube held in the bladder by a small balloon to drain urine) catheter due to urinary retention and BPH (prostate gland enlargement). R414 had pulled on the foley at times causing trauma. Interventions included, "Monitor/record/report to MD (Medical Doctor) for s/sx (signs and symptoms) UTI (urinary tract infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp (temperature), urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns." 1a. Identify signs and symptoms of urinary tract infection: 11/19/20 2:02 PM - In a nursing note, E17 (LPN) documented "...Foley remains intact draining cloudy urine with sediment." 11/20/20 2:00 PM - A nursing note documented "...Foley intact draining clear yellow urine...". 11/21/20 2:01 PM - In a nursing note, E17 (LPN) documented "...Resident had blood coming from his penis with Foley catheter remaining intact. Dr. (Doctor) on call notified (name of Medical Provider) New Foley bag placed. Drainage clear of blood at this time...Foley remains intact...Will pass on in report and will continue to monitor." 11/23/20 2:37 PM - A nursing note documented "...Foley intact draining clear yellow urine...". 11/24/20 2:25 PM - In a nursing note, E17 (LPN) documented "Foley clean and dry and intact draining 350 ml blood tinged urine."	F 690		

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F 690	Continued From page 6 11/25/20 4:12 AM - A nursing note documented "Foley clean and intact, with blood tinged urine." 11/26/20 11:04 AM - In a nursing note, E17 (LPN) documented "...Foley catheter remains intact and draining tea colored urine." 11/29/20 9:58 PM - In a nursing note, E16 (LPN) documented "...Foley catheter draining blood tinged urine to gravity." 12/1/20 9:44 PM - In a nursing note, E16 (LPN) documented "...Foley catheter draining dark brown urine to gravity." 12/2/20 2:28 AM - A nursing note documented "...Foley cath patent and intact draining dark colored urine." 12/2/20 10:39 PM - A nursing note documented "...Foley intact and draining dark yellow urine." 12/4/20 2:13 AM - A nursing note documented "...Foley cath patent and intact draining dark colored urine." 12/6/20 9:36 PM - In a nursing note, E16 (LPN) documented "...Foley catheter draining blood tinged urine to gravity...". 12/8/20 10:08 PM - A nursing note documented "...Foley cath patent and intact draining dark colored urine." 12/9/20 8:48 AM - A nursing note documented that 911 was called to send R414 to the hospital for evaluation because of respiratory difficulty. 12/15/20 - A hospital nursing note documented	F 690		

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F 690	Continued From page 7 when R414 arrived at the hospital on 12/9/20 "pt (patient) found to be retaining more then 1,000 mL urine with purulent (pus) drainage around catheter...". (Normal adult bladder capacity is 300 to 400 ml) 12/18/20 - Hospital Discharge Summary - "Reason for Hospitalization ...Foley associated UTI...presented from (name of long term care facility) found to have occluded Foley exuding pus." 5/5/21 2:30 PM - During a phone interview, E2 (DON) was asked to provide any additional information that the nurses notified the medical doctor of the above assessments of abnormally colored urine. 5/6/21 9:50 AM - During a phone interview, E17 (LPN) confirmed that she only notified the Medical Doctor one of the four times she assessed abnormally colored urine. 5/6/21 10:55 AM - During a phone interview, E16 (LPN) confirmed that he did not notify the Medical Doctor any of the three times he assessed abnormally colored urine. The facility was unable to provide evidence that the nurses notified the Medical Doctor of urine being cloudy, dark or bloody for 11 of the 12 times signs of a UTI were documented. 1b. Procedure for implementing standing orders: April 2017 (last revised) - Facility's standing orders included, "may irrigate urinary catheter as needed." The procedure for standing orders stated:	F 690		

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F 690	Continued From page 8 - Resident assessment by licensed staff. - Initiate appropriate standing order. - Document assessment, standing order, and resident response. - Document notification of physician. - Document or enter the specific intervention on MAR (medication administration record) or TAR (treatment administration record). Review of R414's clinical record revealed: 11/18/20 - A physician order was written to follow standing orders. 11/22/20 10:20 PM - In a nursing note, E15 (LPN) documented "...foley draining amber urine, irrigation done. will continue to monitor." The nurse's documentation did not include that a standing order was initiated, an indication for irrigation, how much fluid was instilled, how much fluid was returned (if any), resident response, or notification of a physician. In addition, the specific intervention of foley catheter irrigation was not entered on R414's MAR or TAR. 5/5/21 2:30 PM - During a phone interview, E2 (DON) stated that irrigating a urinary catheter is on the facility's standing orders. 5/6/21 11:30 AM - During a phone interview, E15 (LPN) stated that because she is an agency nurse and works in many long term care facilities, she does not know all of the protocols in every facility she works. She explained that she routinely irrigates the foley catheters of her residents to prevent clogging, but does not remember specifically why she irrigated R414's catheter. Irrigation without an indication for use is inappropriate and placed R414 at risk for UTI.	F 690		

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F 690	Continued From page 9 5/6/21 10:55 AM - During a phone interview, E16 (LPN) was asked about the facility's procedure for implementing a standing order. He stated that he would notify the Medical Doctor when he implemented a standing order. The nurses failed to identify signs of a UTI and they failed to notify the Medical Doctor. 5/6/21 3:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference.	F 690		
F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, review of a clinical record, and resident and staff interviews, it was determined that the facility failed to ensure that one (R107) out of 66 residents received her preferred and requested diet consistency. Findings include: Review of R107's clinical record revealed the following: 9/30/20 - R107 was admitted to the facility. 4/22/21 - Review of E14's speech therapy (ST) progress note revealed that R107 requested a change from a mechanical diet (smoother texture	F 800	1. R107 is receiving appropriate diet as ordered. E12, E14, and E18 were educated by the DON on following facility procedures for revision of diet orders. 2. All residents were reviewed by the Dietician to ensure that residents received their preferred and requested diet consistency. 3. Speech Therapy, Dietician and Nursing staff will be educated by the DON or designee to ensure residents diet meets their needs. 4. Dietician will audit weekly x 4 and monthly x 3 until compliance is achieved to ensure residents receive diets that	6/21/21

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F 800	Continued From page 10 than regular foods; eliminates foods that are difficult to chew or swallow) to a regular diet. 4/26/21- A Nursing Dietary Communication Slip revealed the requested change from a mechanical to a regular diet. 4/29/21 - A Nursing Dietary Communication Slip revealed the requested change from a mechanical diet to a regular diet. 4/30/21 at 8:25 AM - An observation of R107's breakfast tray in comparison of R107's meal ticket (a form used by the facility where residents make meal selections) indicated a mechanical soft diet with chopped consistency food on the meal tray which did not match with R107's request for a regular diet. 5/4/21 at 9:45 AM - During an interview, R107 stated that she was supposed to have a regular diet and not chopped foods. 5/4/21 at 1:40 PM - During an interview with E18 (Dietician), she stated that R107's meal ticket should have been updated from a mechanical diet to a regular diet on 4/22/21 when submitted by E14. 5/5/21 at 11:00 AM - During an interview, E13 (OT) verified that R107's diet communication slip was completed and sent to E5 (FSD) on 4/22/21 for updating. 5/6/21 at 9:45 AM - Findings were discussed with E5 (FSD). Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit	F 800	meet their needs. Results of the audits will be submitted to the QAPI Committee.	

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	085004	A. BUILDING _____ B. WING _____	C 05/06/2021

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F 800	Continued From page 11 conference on 5/6/21, beginning at approximately 2:45 PM.	F 800		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that for one (R84) out of five residents reviewed for ADL's, the facility failed to provide R84 with special eating equipment and utensils to keep R84 from spilling drinks. Findings include: Review of R84's clinical record revealed: 3/22/21 - R84 was admitted to the facility. 3/23/21 - The resident profile, a document used to provide guidance to CNA's on a resident's care lacked documentation that R84 needed a special cup or a Styrofoam cup with a lid and straw. 3/29/21 - The admission MDS documented that R84 required set up and supervision for eating. The MDS defines eating as the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. Supervision or touching assistance means that staff provide verbal cues and/or touching/steadying and/or contact guard assistance. Independent means	F 810	1. R84 was screened by occupational therapy to assure that resident was provided assistive devices for eating and drinking based on resident's needs. 2. Any residents who exhibits signs/symptoms needing assistive device will be screened by occupational therapy routinely to assure that assistive devices are provided to meet residents needs. 3. Nursing, dietary and therapy staff will be educated on the importance of providing assistive devices for eating and drinking based on individualized residents needs. 4. The Therapy Director will audit residents weekly x 4, and monthly x 3 until compliance is achieved. Results of the audits will be submitted to the QAPI Committee.	6/21/21

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F 810	Continued From page 12 the resident does not require assistance. 4/29/21 12:34 PM - R84 was observed with his hands shaking so bad that he spilled more of the drink than he drank. R84 stated, "I need a straw and bigger cup so I don't spill it on myself, but they (staff) forget it." 4/29/21 1:45 - E12 (LPN) was observed giving R84 a drink in a small Styrofoam cup without a lid and straw. 4/30/21 7:45 AM - During an observation of breakfast delivery R84 asked E10 (CNA) to pour the milk in the sippy cup that was on the tray. 5/3/21 1:58 PM - During an interview with E10 (CNA), E10 revealed they use the resident profile sheet on the inside of the closet door to know what R84 needs for meals. E10 confirmed that the resident profile did not have a sippy cup or a Styrofoam cup with a lid and straw on the profile. E10 said she thinks the kitchen sends a sippy cup with meals. 5/3/21 2:02 PM - During an interview with E5 (Food Service Director), it was revealed that the order comes from speech therapy and then the kitchen puts the information on the meal ticket. 5/3/21 2:06 PM - During an interview with E13 (OT), it was revealed that it was recommended that R84 use a sippy cup for drinking due to the shaking of R84's hands. 5/5/21 1:21 PM - During an interview with E13, it was revealed that she recommended the two handled cup and that speech was working with R84 on liquids.	F 810		

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F 810	Continued From page 13 5/5/21 1:35 PM - During an interview with E14 (ST), E14 stated that R84 was admitted to the facility on honey thick liquids and a pureed diet and was upgraded to nectar thick liquids with R84's preference to use a cup with a lid and a straw in the resident profile. There was a lack of documentation of R84's intervention to use a sippy cup or a cup with a lid and a straw so that any staff member would be alerted that the resident needed one of these for his drinks. 5/5/21 2:10 PM - During an interview with E2 (DON) and E11 (RNAC), it was agreed there needed to be a method to communicate R84's need to have a sippy cup or a cup with a lid and straw with liquids so that R84 does not spill liquids on himself. 5/6/21 3:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 810		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		6/21/21

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F 880	Continued From page 14 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 15 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation as indicated, it was determined that the facility failed to establish and maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections. During random medication pass observations, the facility staff failed to perform hand hygiene when changing gloves and they failed to clean and disinfect the blood glucose meter between resident uses. For R16, the facility failed to change the resident's oxygen tubing and humidifier bottle weekly to minimize the spread of infection. Findings include: Review of the manufacturer's instructions for FORA GD20 Blood Glucose Meter (BGM) revealed the following: - Performing a Blood Glucose Test (BGT): "...5. Wash hands. 6. Put on non-sterile gloves...{After performing the BGT}...16. Remove gloves and wash hands...Cleaning and Disinfecting...advise healthcare professionals to clean and disinfect	F 880	1. E6 and E7 were educated on the following to promote infection control practices: performing hand hygiene before donning and doffing gloves and cleaning and disinfecting blood glucose meters between residents. R16's oxygen tubing and humidifier bottle was changed based on facility protocol. 2. Facility staff was educated by the DON/designee on the importance of following facility policy and procedures on hand hygiene before donning and doffing gloves, and cleaning and disinfecting the blood glucose machine between residents. Nursing staff will be educated on facility protocols for changing and dating oxygen tubing and humidifier bottle. 3. Infection Control policy and procedures will be reviewed to assure that CMS and CDC guidance related to hand hygiene, disinfection, and infection control practices are addressed. The Infection Preventionist/designee will complete the CMS Targeted Covid-19 Training for	

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F 880	Continued From page 16 blood glucose meters between each resident test in order to avoid cross contamination issues...Cleaning Guidelines...use...soapy water or isopropyl (70%-80%) to clean the outside of the blood glucose meter...Disinfecting Guidelines...[document contained various methods for disinfecting the meter including the use of household bleach and EPA approved disinfectants]...". (https://www.manualslib.com/manual/1128321/Fora-Gd20.html?page=13#manual) MEDICATION PASS OBSERVATIONS: 1a. 5/5/21 11:35 AM - E7 (LPN) used hand sanitizer and donned clean gloves then proceeded to perform a Blood Glucose Test (BGT) on R68. After using the Blood Glucose Meter (BGM), E7 failed to clean and disinfect the device. E7 proceeded to remove the contaminated gloves and failed to perform hand hygiene and don a new pair of clean gloves while preparing to perform a BGT on a different resident, R53. 1b. 5/5/21 11:41 AM - E7 (LPN) used the BGM to perform the BGT on R53. After the test, E7 removed the contaminated gloves and failed to wash his hands. An interview with E7 immediately after the observations confirmed that E7 failed to clean or disinfect the BGM and failed to wash his hands between residents during the above observations. Typically, E7 stated that he uses alcohol pads to clean the device after resident use. 2a. 5/5/21 11:55 AM - E6 (RN) used hand sanitizer and donned clean gloves, then proceeded to perform a BGT on R20. After	F 880	Management in order to help facilitate enhanced compliance with infection control and prevention. Health Care Professionals will be trained by the Infection Preventionist/designee on hand hygiene before donning and doffing gloves, cleaning and disinfecting the blood glucose machine between residents. Ad hoc education will be provided by the Infection Preventionist/designee to persons who are not correctly performing hand hygiene prior to and after donning and doffing gloves or cleaning/disinfecting the blood glucose machine. 4.Director of Nursing or other nursing leadership will conduct rounds weekly x 4 then monthly x 3 throughout the facility to ensure staff is exercising appropriate hand hygiene when donning and doffing gloves,or cleaning/disinfecting the blood glucose machine and changing and dating the oxygen tubing and humidifier bottles while assuring that infection control procedures are followed in order to prevent cross contamination. A Root Cause Analysis will be done with assistance from the Infection Preventionist and the QAPI Meeting. The findings of the root case analysis will be addressed as part of the intervention plan.	

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F 880	Continued From page 17 testing, E6 removed her gloves and performed appropriate hand washing, but failed to clean and disinfect the BGM as E6 started to prepare for the next BGT with a different resident, R16. 2b. 5/5/21 12:01 PM - E6 (RN) performed a BGT on R16. After testing, E6 failed to clean and disinfect the BGM as E6 started to prepare for the next BGT with a different resident, R38. 2c. 5/5/21 12:05 PM - E6 (RN) performed a BGT on R38, then wiped the outside of the contaminated BGM with a 70% isopropyl pad (which is appropriate for cleaning the meter), but failed to disinfect the BGM after R38's testing. An interview immediately after the above observations confirmed that E6 cleaned the BGM with a 70% isopropyl pad between resident uses, but E6 was uncertain what was to be used to disinfect the device between resident uses. 5/6/21 9:05 AM - The following facility failures were confirmed with E2 (DON) and E3 (ADON): 1) Perform hand hygiene before putting on clean gloves and after removing contaminated gloves and 2) Clean and disinfect the BGM between residents uses per the manufacturer's instructions. OXYGEN SUPPLIES OBSERVATION: 3. 5/3/2021 11:00 AM - A random observation of R16's oxygen concentrator tubing revealed a hand written date of 4/19/21 when it was last changed. The humidifier bottle lacked evidence of a date. A joint observation was immediately done with E4 (RN) who confirmed the findings that the last time the tubing was changed was more than one week ago and that the humidifier	F 880		

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F 880	Continued From page 18 bottle had no date, thus, it was unknown how long it had been since it was last changed. E4 stated that the facility's policy was that both the tubing and the humidifier bottle would be changed on a weekly basis. 5/6/21 9:05 AM - During an interview with E2 (DON) and E3 (ADON), it was confirmed that the facility failed to ensure that R16's oxygen tubing and humidifier bottle were changed weekly. 5/6/21 3:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference.	F 880		

Infection Control DPOC

1. E1. E6 and E7 were educated on the following to promote infection control practices: performing hand hygiene before donning and doffing gloves and cleaning and disinfecting blood glucose meters between residents. R16's oxygen tubing and humidifier bottle was changed based on facility protocol.

2. Facility staff was educated by the DON/designee on the importance of following facility policy and procedures on hand hygiene before donning and doffing gloves, and cleaning and disinfecting the blood glucose machine between residents. Nursing staff will be educated on facility protocols for changing and dating oxygen tubing and humidifier bottle.

3. Infection Control policy and procedures will be reviewed to assure that CMS and CDC guidance related to hand hygiene, disinfection, and infection control practices are addressed. The Infection Preventionist/designee will complete the CMS Targeted Covid-19 Training for Management in order to help facilitate enhanced compliance with infection control and prevention. Health Care Professionals will be trained by the Infection Preventionist/designee on hand hygiene before donning and doffing gloves, cleaning and disinfecting the blood glucose machine between residents. Ad hoc education will be provided by the InfectionPreventionist/designee to persons who are not correctly performing hand hygiene prior to and after donning and doffing gloves or cleaning/disinfecting the blood glucose machine.

4.Director of Nursing or other nursing leadership will conduct rounds weekly x 4 then monthly x 3 throughout the facility to ensure staff is exercising appropriate hand hygiene when donning and doffing gloves, or cleaning/disinfecting the blood glucose machine and changing and dating the oxygen tubing and humidifier bottles while assuring that infection control procedures are followed in order to prevent cross contamination. A Root Cause Analysis will be done with assistance from the Infection Preventionist and the QAPI Meeting. The findings of the root cause analysis will be addressed as part of the intervention plan.